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CRITICAL ISSUES FOR A NEW ADMINISTRATION

THE STATE'S AGENDA

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MR. DAVID HELMS: Well, I hope that you all can begin to move to your seats, please. In case you thought—in case you thought that Health Policy was only performed by our Federal Government—yeah—I'm here to tell you, maybe even to console you, that we have state governments and a private sector out there, and even if we can't get all that we want from our National Government, we can get it from the states.

We are going to have to stay on schedule and I will encourage to now quickly move to your seats. I knew this would be my hardest job at this conference, getting all of you who want a network back together after a chance to have a reunion, but we'll be having our reunion again over lunch and throughout the rest of the day, so I am going to begin. And I've never had a difficulty rising above the noise of a crowd, and I know my words are so important that you will all want to listen as I tell you that states are looking forward to re-engaging in a dialogue with their National Government about the respective roles in meeting our citizens' healthcare needs.

We have learned a great deal during this last decade of State Health Reform. But the chimes are essentially good—do you like the music? Is it—how's it feel for all of you who are in here doing what we wanted, right? Okay, well the chimes can stop now, and I'm going to tell you that the states are trying to reengage their national government because they want to do something to meet their citizens' healthcare needs. They are closer to the people they serve, and the pressures on them to address these needs are enormous.

We have learned a great deal from this decade, though, of State Health Reform. The states need the national government to both establish policy frameworks and to provide substantial funding for coverage expansions. States value flexibility to tailor major reforms to their circumstances. While the states have benefited, as the rest of the society, from limited growth in healthcare costs in recent years, they are again, quite concerned about the impact sharply rising healthcare costs will place on existing programs, including Medicaid, S-CHIP, State Employees and Safety-Net providers. These financial pressures will in turn limit the extent to which states are able to use their own resources to fund coverage and access

expansions. But states have been innovators and leaders in healthcare policy.

As policy leaders and innovators, states enacted the Children's Health Insurance proposals and insurance market reforms, which many observers believe gave our federal government the confidence that it could then enact the State Children's Health Insurance Plan and HIPAA, the Health Insurance Portability and Accountability Act. So states do lead the way by demonstrating and innovating. They've also lead the way in how we contract with managed care plans, how we development partnerships with a private sector, and how to conduct outreach to persons eligible for governmental assistance.

But even with all the progress that states made in this last decade in trying to expand coverage and access, we know they vary greatly in the number of their uninsured. In a recent study conducted by the Robert Wood Johnson Foundation's State Coverage Initiative Program by researchers at Mathematica Policy Research predictably found that the wealthier states are able to do more, and they do more. And even with federal matching rates designed to equalize the comparative disadvantage in their economic capacity, the states near the bottom in Medicaid or in enrolling children in CHIP, have been unwilling to increase the share of their state resources for these programs. This inevitably leads us to the conclusion that we will need the federal funding, and perhaps changes to our federal programs to get significant expansion.

You've heard a lot about the role of states from President Bush's campaign proposals, Gail Wilensky again this morning, and you know the experience of Secretary of Health and Human Services, Tommy Thompson, and what he gained in his 14 years of Governor of that state, that this new Administration will run its programs in a way that provide states with more flexibility in program design. In fact, as I was talking with our presenters while we were waiting for this campaign to be resolved, they were saying, well we're really not sure. With Gore, we might get more money, but with Thompson, we might get more flexibility. We're not sure which we want. But clearly the states do value that flexibility. There are valid strategies on the table, be they expanding public programs or be they using tax subsidies, but the reality of those programs is that they will need the states for their implementation and administration.

So now that you're all back in this room and it is quiet, you will have the opportunity to hear from two states that have been leaders in State Health Reform and pioneers in pushing the envelope of federal programs in order to tailor them to their needs. Both Tennessee's TennCare Program and Washington's Insurance Market Reform and Basic Health Plan, and other innovations, are seen as bellwethers and testaments to what states can do when given the flexibility to develop innovative programs.

You'll hear first from Dennis Braddock, Chief Executive Officer of the Washington State Department of Health and Human Services. He oversees all the social and health programs for that state. He was formerly an Executive Officer of the Community Health Plans of Washington and the Community Health Network, and before that, served in the House in Washington State and Chair of the House Healthcare Committee. So I will welcome Dennis Braddock after I introduce John, while I'm here.

John is Deputy to the Governor for Health Policy, and Deputy Commissioner for the Tennessee Department of Finance and Administration. Governor Sundquist asked him to be the State's top Healthcare Executive for responsibility for the TennCare Bureau, Mental Health, Mental Retardation, and other services provided by the state, and he coordinates health issues for the department. So we'll hear first from Dennis, then from John.

MR. DENNIS BRADDOCK: Thank you, thank you. It's a pleasure to be here. On behalf of the State of Washington, I want to tell you what an honor it is to be here among such distinguished experts in the healthcare field. And as Robert Reischauer suggested, the analogy of being a head waiter, we in the state level, look at ourselves somewhat as a scullery crew in the restaurant.

I would say, tomorrow is Ground Hog Day, and for those of us speaking from the state's perspective, we're wondering if the sun will be shining or that a shadow will be cast—Healthcare cost shadow cast, such that we won't be able to balance our budgets and won't be able to see the light of day. I'd say if anyone here is from Philadelphia, hopefully you can have a chat with Punxsutawney Phil and ask him to see it our way, and that the shadow is not cast so broad over our future.

I bring greetings from Governor Locke, Gary Locke, who is the governor of the State of Washington, and I am here to report on what is going on in the State of Washington. We have been a Bellwether State in the healthcare economic area.

We've been struggling with healthcare reform and access issues for more than a decade, and the slide before you shows what we have done over the past 15 years. The chart shows that about 16 eligibility enhancements that have taken place in as many years. These efforts have been progressive and comprehensive, and include such things as the State's Basic Health Plan, which, for almost eight years, has insured low income working people and has about 140,000 adults enrolled in that state only paid for program in Washington.

In addition to that, in Medicaid, we're providing medical benefits for two out of every five children in our state, almost half the births in our state are paid for by Medicaid. And benefits to children have been extended to 250 percent of federal poverty level, and we offer one of the most

comprehensive menu of services, including optical benefits for adults, and are one of 15 states with full adult—full dental benefits for adults.

This session, the legislature will see the usual number of benefit expansion proposals. One has already been introduced to increase the number of acupuncture sessions offered in a year. But at the same time, like other states, we are under intense spending pressures, and those pressures have forced us to curtail some of our social service spending, and that includes some cuts in healthcare.

What people need to understand when they think about Medicaid is a vehicle for universal access to healthcare is that, at the state level, healthcare is a social services expenditure that competes with other traditional social services. In the chart before you there shows, in the state of Washington, over a about 25-26 year period, annual—biannual increases in our biannual budget, and then on the far right side, you'll see in 1993 in the state of Washington we were blessed with the initiative process, and in 1993 an initiative was passed to limit expenditure growth and that initiative—called Initiative 601, limited growth to about four or five percent biennium for the state budget. Those spending limits, since they've been imposed, as you can see in that chart, growth has been, and our budget has been, significantly curtailed. And I'm here to tell you that as a—much different conversation with the citizens of the state when resources are getting as tight as they are in Washington. The debate is contentious and it is much different to talk to providers when you are decreasing their reimbursement, than when you are adding to their bottom line profits.

In the next chart you can see it shows us—it shows that—how expenditures have grown in the state of Washington over the last 12 years. We've gone from about \$1 billion spent on healthcare in the 87-89 biennium, to a projected \$5.1 billion in the coming biennium, in the 0103 biennium. Also on that chart, you can see we began Managed Care for the TANIF population, that is, for the pregnant women and children population, and it shows the percentage of our population—our percentage of our expenditures that are within Managed Care. And although it is a smaller percentage than in the Fee For Service Program, it is a majority of the population that we cover.

The Managed Care enrollment certainly did improve access and exerted some cost control, but it appears that we are running out of the ability to control those costs. And, of course, despite all of these efforts, medical expenditures continue to rise. And now we're looking at new ways to manage costs and/or cut back on services.

This next chart really illustrates how healthcare cost increases are impacting the state's budget. There was a time when I was in the legislature, healthcare cost increases were not considered a significant

element at all in budget increases. Healthcare cost increases in the coming biennium account for half the budget increase. And it is very clear now that healthcare increases are driving the State of Washington budget.

And the story here is, is that the pressure is building in the agency. I am the Secretary of the Department of Social and Health Services, it is an umbrella agency. In that agency, which provides many Social Services, in addition to Healthcare, we have seen growth in medical costs. Agency medical, in 1987/89 biennium, was 23 percent. In the coming biennium it will be 42 percent of the State Agency budget. That is significant crowding out and competition with other services.

And in our state, politicians continue to rank such things as transportation and education as their top priorities and social services usually get much less attention. So, the increasing expenditure and percent of our budget that goes to health services is crowding out children's services, adult family services, nutrition, daycare, those kinds of services. And when the healthcare system requires ever increasing amounts of limited resources, it makes meeting these other needs extremely difficult. The mentally ill, the developmentally disabled or abused children, are not getting the same kind of increases and attention and budget attention as is healthcare.

And I think that we all know that states are feeling the pressure. This is an article from the New York Times referring to the double digit inflation increases we're experiencing, and then another article from the Wall Street Journal this past month, indicating in that line there—in that headline exactly is what is happening in Washington: Falling Receipts and Rising Medicaid Costs Threatens Spending Levels and Popular Tax Cuts. That is exactly what is happening in Washington and the conversation is getting very heated, the budgets debates very contentious.

This next chart illustrates just an example of the drug cost increases. Back in 87-89, we spent about \$121 million on pharmaceuticals. We're projected to spend nearly \$1 billion in the coming biennium. And as you can see on the right hand side of that slide, our total enrollment, while it has increased considerable, in fact, more than doubled, it does not account for all our expenditure increase. The expenditure increase in entering that same time period has been five fold, the enrollment increase has been about two fold is all. And, as you can expect, we're finding it very difficult to explain to taxpayers why we can't control our costs.

We, like other states, are looking other sources of revenue to solve the problem. As you can see on this chart, the federal fund participation has increased from 47 percent to 51 percent, and other fund sources, those are funds, primarily from the tobacco settlement moneys, have helped us—helped us to balance our budget when it comes to healthcare expenditures. We've had windfalls, as many states have in the tobacco

settlement, but we know that we cannot continue the level of increases we've experienced, and those that we project, under current budgets.

The other activities happening, and I suspect it's occurring in every other state, is that the care providers, the people who provide the care, are getting very cranky about all of this and are insisting that Medicaid is the cause of their budget problems. I would argue that Medicaid, while increasing by five fold over the last 12 years, certainly should not be identified as not doing its part. In fact, I believe that we can make an excellent case that there's been significant cost shift from the private sector to the government sector in the past 12 years.

We're getting calls from purchasers who—saying they do not want to continue the Medicaid Program—not purchasers, providers. We're getting calls from providers who say that they don't want to continue in the Medicaid Program. Hopefully that does not become a more serious problem. But really, in the state of Washington, we are waiting for the inevitable train wreck, and when the state can't afford more funding and the federal government won't bail us out, and our private providers are screaming for additional funds that we don't have. Hopefully they won't leave us in the lurch, but we do believe the train wreck is coming. We watch and we wait and we hope to avoid that wreck, but it's there in the mirror and it's gaining on us and I suspect we will be that little yellow truck.

Well, and for the short term, what we're doing is, we're working our way up the list of optional services and making cuts in those optional services. We've proposed for the next budget to cut adult dental, we are reducing our contribution in the medically—state only medically indigent program, and we have proposed a cut of vision—optical benefits. And what's next, we will eliminate additional optional services, we could discount our vendor rates—that is, discount our rates to providers, but that could cause us to lose the infrastructure, and we could begin to reduce eligibility thresholds after more than a decade of increasing eligibility thresholds, we could begin to reduce those. And frankly, we will have to do that if we cannot control our costs.

The—what we need from the federal government, and from the public in general is, I believe, recognition that Medicaid, in and of itself, can't solve the problem of healthcare access. If universal access is a goal, there must be a national participation beyond Medicaid. Again, Medicaid, I think many people have thought, could solve the universal access goal. It cannot. There must be national participation in order to get us there beyond Medicaid.

We need support for cost control efforts for those of us who are the front lines of implementation. Cost control efforts have been sporadic and

largely unsuccessful in the past. We need to have partnership with the federal government to enable us to better control costs.

We need greater flexibility. I believe we need to see co-pays and/or premium share options at higher income levels; we need more flexibility in program implementation; and, I believe we need a holiday or a hiatus from ever changing data reporting requirements, at least for a while. And I would go on—beyond that, to say that we should seriously consider a delay in HIPAA implementation. I don't believe our provider partners will be able to meet the requirements of HIPAA. I believe we, as a state, can do our part largely because of generous federal support for the state. But I do not believe providers will be able to meet the HIPAA requirements in the two year period. We also need, if we are expected to continue the Medicaid, we need sustained commitment from the federal level, and hopefully we will be getting that, along with flexibility, with this Administration.

We're bracing ourselves for a time when it's going to get tougher. We don't see a solution to these problems immediately. We're going to need dynamic leadership and creativity more than ever before, and the question that we have to ask is, are we ready?

We look forward to partnering closer with the federal government, but reminding them that, just more money that we have to match is not the solution for expanding access, and that we need them to work with us to provide flexible cost control measures in our programs. Thank you.

MR. JOHN TIGHE: In the interest of time, we got a little behind there because our break, I guess, went a little long. I'm going to begin by telling you, thank you for having me here. I bring you greetings from the great state of Tennessee. Currently, we'll talk about the Lady Balls if you'd like. We only talk about the good news, we don't talk about the bad. Governor Don Sundquist, our Governor, sends his greetings.

I am going to share with you today some perspective from the state of Tennessee, but I want you to know what my hypothesis is, and that is that, while funding is a huge issue with the federal government, flexibility is more important than anything else because, with every federal dollar, come so many strings that, by the time you get the dollars, you can't pull off the program and that's a huge crisis, I think, for all of us.

So the states, who have always been the innovators, as David pointed out, had been incubators, have tried new things, whether it's Welfare to Work, or CHIP Programs, or expanding populations beyond Medicaid, the states have played important roles. I'm going to bring you the example of the state who has tried to really innovate and do some interesting things, that's now really between a rock and a hard place and—in trying to deliver services.

For those of you who don't know Tennessee, I'm going to go through a few quick slides. I'll probably go too quickly, and I promise that I'm going to get off here on time, so if I don't get finished with my presentation, I'm just going to say thank you and sit down because it is not easy and it's fairly complicated. But keep in mind, that if there is ever a state that provides generally universal healthcare coverage, the state of Tennessee does and it does it not at income levels, it is open to all people regardless of income size. So, I'm going to hit—kind of go through this, but kind of keep that one in mind.

First of all, what is TennCare? It's a Managed Care Program that was created in '94, it is an 1115 Waiver, and its focus was to provide poor and uninsured Tennesseans access to healthcare insurance. It expanded the Medicaid Program to uninsured and uninsurable adults and children. It totals \$5.2 billion for 2001, keeping in mind 3.7 is actually the Medical and Behavioral Care Program and the other, MHMR, all other kind of single state agency, is another 1.5. So, it's really a total of 3.7.

The features of the program are it's managed through HMO's. So this is a private—this is a turning over the risk to HMO program. We have carve outs in a few areas that have happened over the life of the program. First of all, behavioral is carved out. In other words, it is a separate behavioral health organization. It is not part of the Managed Care organization cap payments. Long term care is a state program, managed by the state and Medicare cost sharing and pharmacy, is state. In other words, for our Medicare duals, we carry and take care of the pharmacy benefit.

Current challenges, and I'm going to talk about other challenges, but you would probably wonder why I was up here talking if I didn't tell you that our largest HMO is an exigency, which means they've said they're leaving the program and we've had to extend them to take care of our members. Our second largest is in supervision, and our third is in court ordered rehabilitation. So what—but really we have no problems, everything is really going quite well in the State of Tennessee. This private--private partnership is really just knocking us out.

Now, there are a lot of reasons for that, ladies and gentlemen. I don't want you to think that it's because they're bad and everything. I'm telling you that part of the reason for this is we took an expanded program and, de facto, turned it into an entitlement program for this expanded population, put all the bureaucracy around it and all the rules and regulations, funded based on whatever we happened to have had available, not as an insurance product, and did that for 1.4 million Tennesseans. It's not surprised that the system has started to crumble and we're seeing real, real problems with it right now.

Having said that, we are the volunteer state, we never lay down and die. We have picked ourselves back up and we have put together a new business model. And here's a novel thought, it's actuarially funded. In other words, it is based on the actuarial data. We have lots of great actuaries, we usually just ignore them when they would tell us the facts. So this time, instead of that, we have really gone independently and have actually based the program on actuarial funding. Now there are 20 rate cells. They're not only age breakdowns, but they're also different rates elsewhere for uninsured, uninsurable and Medicaid populations, and you'll see a little of that in a second.

There're also risk and utilization adjusted. Our state is a wonderful state with its diversity, but it is very diverse, translated, that there is very different utilization across our state, very similar to the utilization patterns across our country. They're not the same. And so we found that we had to make risk orders and adjustments to the rates based on just where the people were living, because our utilization is significantly higher, for example, in the eastern part of our state and our risk is different in different parts of the state, obviously higher in many of our rural communities.

There are also three profit and loss risk band options, which means that the HMO's now don't—we don't pass off all the risk, they can take full risk, they can have a shared risk at break even, in other words, we will share at break even, or there's also what we call a no blood zone. So, they can keep two percent of the profit, they keep two percent of the loss, anything beyond that we share. You get the concept.

So who do we—luckily I'm a southerner who's really a Yankee, I'm going to talk real fast. We try to shuffle in the south, you know, you don't want to use up too much energy, you sweat. Doesn't mean we're stupid though, now don't you go thinking that.

Population of TennCare, just three slides here that will give you a real fast snapshot of where we are. The population is, as you can see, 802,000 Medicaid, 553,000 what we call the expanded population; translated, they're uninsured and uninsurable individuals, about 409,000 uninsured, 143 uninsurable, uninsurable based on their inability to get insurance because of medical condition.

How does it break down? Children and adults. 553 children, 802 adults. I'm going to be referring to some numbers later around that adult population, because we're coming to the point where, what is really the optional part of the TennCare Program? What's really option is that 212,000 uninsured and that 137,000 uninsurable adults. I—we're obviously going to take care of Medicaid, and we would be hard pressed to think that we're going to drop our children, no matter what happens going forward. If—at a minimum, we will put them into a CHIP Program.

Then, how does it go by poverty level? Lots of national, local, pressed, you name it, go to the mall, go anywhere, and you hear that we got all these driving Lexus. Well, the fact of the matter is, that's not the population. The population is dominantly, as you can see, below 200 percent of poverty. There are 3,000 children, 20,000 adults above. Those are generally uninsurable individuals, by the way, which is why they would be on the program, because they don't have access to it any other place.

So what's it cost? Here's what our rates are. It was interesting how some of these programs all stick together because, we were talking earlier about the federal and the voucher systems, and I'm standing here before you telling that our average cost per enrollee, again, back to these rate cells when you kind of roll them all up, is that our children basically are running somewhere between \$1,000 and \$1,800. If the child is uninsurable, it's costing us more to provide coverage or buy a premium, if you want to call it, for that child. But they're basically \$1,000 to \$1,800 and, as you know, there wouldn't be any Medicaid duals.

Adults, on the other hand, this is where the variation has really been fascinating as we now start to pay for it actuarially. And that is, that the uninsurable individual is a \$4,000 a year cost. Now this is based on an actuarial study that is pretty consistent with public programs. In other words, 85 percent of Medicare on physician rates, \$8,000--\$800, pardon me, average premiums for hospitals. You know, it's kind of the traditional approach of funding. It's \$4,000, uninsured \$2,000, so, and the Medicaid duals, you can see what's happening to drug costs, because the duals costing us \$1,500 and, basically, we're doing a little transportation and paying for their drugs, so you can see what's going on there.

That's all background to talk about, and hopefully I didn't—yes I'm did, I'm sorry. I went too fast. This is just a slide that's real important to us, but I want to make my point. And my point is that, if you look at where the money comes from, actually, most of the money does not come from the state general fund. We are spending, on average, \$367 for an uninsured, or \$610 for an uninsurable adult, these are adults, to provide this health benefit for them. Why? Because in our waiver we can charge a premium tax, which we do to the HMO's, so that goes into the coffers. We have, obviously, the federal participation, which goes in. Our other, because we're able to collect premiums, we're able to use CPE, Certified Public Expenditures, as part of our funding mechanism. When you put it all together, it's about 18 cents on the dollar comes out of the general fund. So it's a good deal for Tennessee. And it also questions—let me go back. You can save \$137 million by dropping the people. That's what it would save the State of Tennessee on the general fund. So, but, I told you, we've got plenty of challenges.

So let me go down beyond the big three, dropping. Enrollment growth. Two reasons. Enrollment growth because we're seeing a shift from the private sector. You know, like so many programs, you have to have mechanisms in place to make sure that you aren't seen just people moving into programs. We have actually had to close to uninsured adults because of the growth rate.

We also have issues of denial of individuals for healthcare coverage. It looks like it's on the increase. It's a challenge for us, especially in the State of Tennessee, because we have high disease incident rates.

The third, and the most critical, is the courts are killing us. We are held accountable. We are held to the same standard as a Medicaid Entitlement Program for our expanded population and are now in a restraining order, temporary restraining order, which keeps us from taking anyone off the program that is neither dead or request in writing twice for—to be removed from the program. So we're seeing growth.

What does that mean? That means that for every 10,000 people, just to give it to you of enrollment growth, it's \$50 million of total cost. That's not—that's total cost. And so, if you look at it this year, we are seeing 90,000 growth from last year in the program. It's a huge challenge.

The other is—drug costs are obviously an issue. Drug cost, we're estimating in our actuarials this year that 16.5 percent overall medical inflation on our program is looking—it's going up five—three to five on the medical, eight on the behavioral. So the costs just keep continuing to climb. Public commitment is a huge issue for us, obvious because of the tax barer, the tax base.

Second challenge is access. We are woefully inadequate in our dental access. I know that's not unique to other states, but if the Feds want to take on an issue, let's take on children's dental. It is a massive, massive problem. We just did a Head Start study that I'm embarrassed to tell you resulted in 60 percent of our children in the Head Start Program out of the sample, had decay, and this is with universal coverage.

Second is provider commitment, especially specialty physicians. They're not writing and talking about dropping out, they are dropping out. And when you don't have specialists, primary care physicians don't have anyone to refer to. So it's a wonderful thought to have commitment to our community centers and to our federally qualified health centers and those kinds of entities, but if there's no place to send the patients for specialty care, it just doesn't work.

Third area's members. Smooth member transition. We are transitioning 650,000 lives in April from the old HMO's to the new HMO's and so that's

obviously a challenge. I mention lawsuits and consent decrease and, without risking being sued again, I'll shut up.

Due process and appeals. HMO liability is an important issue for all of us and it's an issue nationally as well as locally, but appeals processes have not been put in place, in my opinion, and I'm new to state government over the last few years, that give you good infrastructure. It's a wonderful thought, but it takes a lot of effort. And when the infrastructure isn't there, you end up without the kind of appeal process you need for members.

Continuing. Commercial HMO's are not participating. I already told you about that in general, but Prudential came out in 1999, Blue Cross came out in 2000, United dropped out of the procurement that came in the procurement, they were ranked number one and, after they looked around for a while they said, we're getting out of Dodge.

TennCare's become the whipping boy for all the state's problems. Program integrity is an issue. You need fraud units out there all the time to try to keep integrity in the program. I think we've got a great program integrity unit, but it's constantly an issue, people being inappropriately taken off of plans.

Slow and indecisive HCFA. It is like glue. It is just too slow, too indecisive. We have had a request to close to uninsurable because of our crisis for over 18 months. Haven't even gotten a response. We have waited over a year for approval on flat co-pays and deductibles, just got it. It's just really out of control.

What has TennCare accomplished? Let me just real quickly—increased access to healthcare, significantly we have seen that. Decreased number of uninsured Tennesseans. Our uninsured children now is dropping below four percent. Increased primary care and preventive services. Decreased inappropriate use of ER services. It's literally gone in half with the program of people going to the ER for their primary care. Decreased in-patient admissions in days. Significant changes across all disease categories, but especially around areas like asthma, children's asthma, those kind of areas. Improved health outcomes, significant ones, and we've achieved it for a lot of people; one of 2.4 Tennessee children, one in five adults, Tennesseans living in poverty, the working poor, and Tennesseans with preexisting medical conditions. So the conclusion is TennCare is a good deal for Tennesseans, but we need federal commitment.

Why is it a good deal? For approximately 18 percent of the cost, we are providing needed healthcare insurance to approximately 350,000 adult Tennesseans who lack insurance. Second, we have a healthcare insurance

program for uninsured, uninsurable adults with a better federal match than even a CHIP program.

Be jealous, but you got to take the rest of it with it.

Tennessee economy benefits from an additional \$663 million in federal funds. That benefit would be lost if we didn't have TennCare. And despite the many challenges, Tennessee has achieved significant improvements in health outcomes, but, punch line, we need federal commitment. My themes are flexibility, better coordination among discrete programs, one wonders sometimes if they ever talk to one another, and significantly improved communication between HCFA and the states.

Specifically, stop raising the requirements for Managed Care Programs. HCFA continues to raise the bar on Managed Care Programs as opposed to Fee For Service and non-Managed Care Programs. We've got to stop doing that. We can't keep just kind of sticking it to the Managed Care companies, we have to start working better and not raising that bar.

Simplify the waiver renewal process. It seems like we're constantly renewing our waivers, we're constantly updating them. We need to do that. Help us to maintain the—yeah, it's like all you do is write, you know, you just keep on writing. Help us maintain the fiscal integrity of the current programs. Cost sharing was mentioned earlier by Dennis, incredibly important. Use of excess S-CHIP funds to enhance services. If states have not used their CHIP money, let them use it to expand services. We already mentioned that dental is a huge problem with our children. Get those dollars and get them into other programs, just don't take them back.

Flexibility in containing drug cost, and I'll come to some issues around that, but especially around the pharmacy and the formularies. Get away from the all or nothing approach. Benefit package design doesn't have to be all or nothing. It ought to reflect more like the private sector. We've got to be able to quickly change benefits in limited enrollment. When you've got a program going, if it's not working, you need to be able to adapt it and change it and not be putting in and spending years trying to get compromising agreement on how to do that, and while you're doing that, the whole thing's going down the toilet.

We also need to target our home on community based services so that we can do more targeted things that make sense in local communities, not just across the country.

And finally, we need to encourage cooperation and coordination with the private sector. And what I mean by that is, we need to give states freedom to set reasonable cost sharing. If we don't have it look something like the private sector, we're really shooting ourselves in the

foot. We need the private sector, we need those partnerships. We need freedom to use Medicaid funds to pay for part of the share, employee share of premiums. There's no reason. We put children on TennCare all the time because their parents live below poverty levels. We'd be far better vouchering them and having them on and staying on their parents coverage and not splitting up families. We need the flexibility to be able to do that and some states are doing that. Massachusetts is doing it. I'm glad to see some innovations.

And finally, tiered co-pays and coinsurance for pharmaceuticals similar to the private sector. We ought to be able to charge differently co-pays based on generic and other brands. And, finally, I am finished on time and if you want any additional information, or if you'd like to look at the slides, or you want to see anything, go on [www.state.tn.us/tenncare](http://www.state.tn.us/tenncare). Thank you very much.

MR. HELMS: Well, I feel better knowing we have states out there trying. I know you do. I'm going to thank this panel. We'll stay on our schedule and invite Dr. Bill Roper and his panel to come up now. As they're arriving and this group is leaving. I will let you know what's going to happen for lunch. It's a wonderful lunch. It's going to be served out where you had coffee and you registered this morning. They've already set it up for us. You'll be there for about—

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